

REFERENCE TITLE: insurance; cancer treatment; medical references

State of Arizona  
House of Representatives  
Forty-ninth Legislature  
First Regular Session  
2009

# HB 2558

Introduced by  
Representatives Ash, Barto

AN ACT

AMENDING SECTIONS 20-826, 20-1057, 20-1343, 20-1402, 20-1404 AND 20-2326,  
ARIZONA REVISED STATUTES; RELATING TO CANCER TREATMENT.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 20-826, Arizona Revised Statutes, is amended to  
3 read:

4 20-826. Subscription contracts: definitions

5 A. A contract between a corporation and its subscribers shall not be  
6 issued unless the form of such contract is approved in writing by the  
7 director.

8 B. Each contract shall plainly state the services to which the  
9 subscriber is entitled and those to which the subscriber is not entitled  
10 under the plan, and shall constitute a direct obligation of the providers of  
11 services with which the corporation has contracted for hospital, medical,  
12 dental or optometric services.

13 C. Each contract, except for dental services or optometric services,  
14 shall be so written that the corporation shall pay benefits for each of the  
15 following:

16 1. Performance of any surgical service that is covered by the terms of  
17 such contract, regardless of the place of service.

18 2. Any home health services that are performed by a licensed home  
19 health agency and that a physician has prescribed in lieu of hospital  
20 services, as defined by the director, providing the hospital services would  
21 have been covered.

22 3. Any diagnostic service that a physician has performed outside a  
23 hospital in lieu of inpatient service, providing the inpatient service would  
24 have been covered.

25 4. Any service performed in a hospital's outpatient department or in a  
26 freestanding surgical facility, if such service would have been covered if  
27 performed as an inpatient service.

28 D. Each contract for dental or optometric services shall be so written  
29 that the corporation shall pay benefits for contracted dental or optometric  
30 services provided by dentists or optometrists.

31 E. Any contract, except accidental death and dismemberment, applied  
32 for that provides family coverage ~~shall~~, as to such coverage of family  
33 members, SHALL also provide that the benefits applicable for children shall  
34 be payable with respect to a newly born child of the insured from the instant  
35 of such child's birth, to a child adopted by the insured, regardless of the  
36 age at which the child was adopted, and to a child who has been placed for  
37 adoption with the insured and for whom the application and approval  
38 procedures for adoption pursuant to section 8-105 or 8-108 have been  
39 completed to the same extent that such coverage applies to other members of  
40 the family. The coverage for newly born or adopted children or children  
41 placed for adoption shall include coverage of injury or sickness including  
42 necessary care and treatment of medically diagnosed congenital defects and  
43 birth abnormalities. If payment of a specific premium is required to provide  
44 coverage for a child, the contract may require that notification of birth,  
45 adoption or adoption placement of the child and payment of the required

1 premium must be furnished to the insurer within thirty-one days after the  
2 date of birth, adoption or adoption placement in order to have the coverage  
3 continue beyond the thirty-one day period.

4 F. Each contract that is delivered or issued for delivery in this  
5 state after December 25, 1977 and that provides that coverage of a dependent  
6 child shall terminate upon attainment of the limiting age for dependent  
7 children specified in the contract shall also provide in substance that  
8 attainment of such limiting age shall not operate to terminate the coverage  
9 of such child while the child is and continues to be both incapable of  
10 self-sustaining employment by reason of mental retardation or physical  
11 handicap and chiefly dependent upon the subscriber for support and  
12 maintenance. Proof of such incapacity and dependency shall be furnished to  
13 the corporation by the subscriber within thirty-one days of the child's  
14 attainment of the limiting age and subsequently as may be required by the  
15 corporation, but not more frequently than annually after the two-year period  
16 following the child's attainment of the limiting age.

17 G. No corporation may cancel or refuse to renew any subscriber's  
18 contract without giving notice of such cancellation or nonrenewal to the  
19 subscriber under such contract. A notice by the corporation to the  
20 subscriber of cancellation or nonrenewal of a subscription contract shall be  
21 mailed to the named subscriber at least forty-five days before the effective  
22 date of such cancellation or nonrenewal. The notice shall include or be  
23 accompanied by a statement in writing of the reasons for such action by the  
24 corporation. Failure of the corporation to comply with ~~the provisions of~~  
25 this subsection shall invalidate any cancellation or nonrenewal except a  
26 cancellation or nonrenewal for nonpayment of premium.

27 H. A contract that provides coverage for surgical services for a  
28 mastectomy shall also provide coverage incidental to the patient's covered  
29 mastectomy for surgical services for reconstruction of the breast on which  
30 the mastectomy was performed, surgery and reconstruction of the other breast  
31 to produce a symmetrical appearance, prostheses, treatment of physical  
32 complications for all stages of the mastectomy, including lymphedemas, and at  
33 least two external postoperative prostheses subject to all of the terms and  
34 conditions of the policy.

35 I. A contract that provides coverage for surgical services for a  
36 mastectomy shall also provide coverage for mammography screening performed on  
37 dedicated equipment for diagnostic purposes on referral by a patient's  
38 physician, subject to all of the terms and conditions of the policy and  
39 according to the following guidelines:

40 1. A baseline mammogram for a woman from age thirty-five to  
41 thirty-nine.

42 2. A mammogram for a woman from age forty to forty-nine every two  
43 years or more frequently based on the recommendation of the woman's  
44 physician.

45 3. A mammogram every year for a woman fifty years of age and over.

1 J. Any contract that is issued to the insured and that provides  
2 coverage for maternity benefits shall also provide that the maternity  
3 benefits apply to the costs of the birth of any child legally adopted by the  
4 insured if all of the following are true:

5 1. The child is adopted within one year of birth.  
6 2. The insured is legally obligated to pay the costs of birth.  
7 3. All preexisting conditions and other limitations have been met by  
8 the insured.

9 4. The insured has notified the insurer of the insured's acceptability  
10 to adopt children pursuant to section 8-105, within sixty days after such  
11 approval or within sixty days after a change in insurance policies, plans or  
12 companies.

13 K. The coverage prescribed by subsection J of this section is excess  
14 to any other coverage the natural mother may have for maternity benefits  
15 except coverage made available to persons pursuant to title 36, chapter 29  
16 but not including coverage made available to persons defined as eligible  
17 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If  
18 such other coverage exists the agency, attorney or individual arranging the  
19 adoption shall make arrangements for the insurance to pay those costs that  
20 may be covered under that policy and shall advise the adopting parent in  
21 writing of the existence and extent of the coverage without disclosing any  
22 confidential information such as the identity of the natural parent. The  
23 insured adopting parents shall notify their insurer of the existence and  
24 extent of the other coverage.

25 L. The director may disapprove any contract if the benefits provided  
26 in the form of such contract are unreasonable in relation to the premium  
27 charged.

28 M. The director shall adopt emergency rules applicable to persons who  
29 are leaving active service in the armed forces of the United States and  
30 returning to civilian status including:

- 31 1. Conditions of eligibility.
- 32 2. Coverage of dependents.
- 33 3. Preexisting conditions.
- 34 4. Termination of insurance.
- 35 5. Probationary periods.
- 36 6. Limitations.
- 37 7. Exceptions.
- 38 8. Reductions.
- 39 9. Elimination periods.
- 40 10. Requirements for replacement.
- 41 11. Any other condition of subscription contracts.

42 N. Any contract that provides maternity benefits shall not restrict  
43 benefits for any hospital length of stay in connection with childbirth for  
44 the mother or the newborn child to less than forty-eight hours following a  
45 normal vaginal delivery or ninety-six hours following a cesarean section.

The contract shall not require the provider to obtain authorization from the corporation for prescribing the minimum length of stay required by this subsection. The contract may provide that an attending provider in consultation with the mother may discharge the mother or the newborn child before the expiration of the minimum length of stay required by this subsection. The corporation shall not:

1. Deny the mother or the newborn child eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract solely for the purpose of avoiding the requirements of this subsection.

2. Provide monetary payments or rebates to mothers to encourage those mothers to accept less than the minimum protections available pursuant to this subsection.

3. Penalize or otherwise reduce or limit the reimbursement of an attending provider because that provider provided care to any insured under the contract in accordance with this subsection.

4. Provide monetary or other incentives to an attending provider to induce that provider to provide care to an insured under the contract in a manner that is inconsistent with this subsection.

5. Except as described in subsection O of this section, restrict benefits for any portion of a period within the minimum length of stay in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

O. Nothing in subsection N of this section:

1. Requires a mother to give birth in a hospital or to stay in the hospital for a fixed period of time following the birth of the child.

2. Prevents a corporation from imposing deductibles, coinsurance or other cost sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn child under the contract, except that any coinsurance or other cost sharing for any portion of a period within a hospital length of stay required pursuant to subsection N of this section shall not be greater than the coinsurance or cost sharing for any preceding portion of that stay.

3. Prevents a corporation from negotiating the level and type of reimbursement with a provider for care provided in accordance with subsection N of this section.

P. Any contract that provides coverage for diabetes shall also provide coverage for equipment and supplies that are medically necessary and that are prescribed by a health care provider including:

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

3. Test strips for glucose monitors and visual reading and urine testing strips.

4. Insulin preparations and glucagon.

5. Insulin cartridges.

6. Drawing up devices and monitors for the visually impaired.

1           7. Injection aids.  
2           8. Insulin cartridges for the legally blind.  
3           9. Syringes and lancets including automatic lancing devices.  
4           10. Prescribed oral agents for controlling blood sugar that are  
5 included on the plan formulary.  
6           11. To the extent coverage is required under medicare, podiatric  
7 appliances for prevention of complications associated with diabetes.  
8           12. Any other device, medication, equipment or supply for which  
9 coverage is required under medicare from and after January 1, 1999. The  
10 coverage required in this paragraph is effective six months after the  
11 coverage is required under medicare.  
12           Q. Nothing in subsection P of this section prohibits a medical service  
13 corporation, a hospital service corporation or a hospital, medical, dental  
14 and optometric service corporation from imposing deductibles, coinsurance or  
15 other cost sharing in relation to benefits for equipment or supplies for the  
16 treatment of diabetes.  
17           R. Any hospital or medical service contract that provides coverage for  
18 prescription drugs shall not limit or exclude coverage for any prescription  
19 drug prescribed for the treatment of cancer on the basis that the  
20 prescription drug has not been approved by the United States food and drug  
21 administration for the treatment of the specific type of cancer for which the  
22 prescription drug has been prescribed, if the prescription drug has been  
23 recognized as safe and effective for treatment of that specific type of  
24 cancer in one or more of the standard medical reference compendia prescribed  
25 in subsection S of this section or medical literature that meets the criteria  
26 prescribed in subsection S of this section. The coverage required under this  
27 subsection includes covered medically necessary services associated with the  
28 administration of the prescription drug. This subsection does not:  
29           1. Require coverage of any prescription drug used in the treatment of  
30 a type of cancer if the United States food and drug administration has  
31 determined that the prescription drug is contraindicated for that type of  
32 cancer.  
33           2. Require coverage for any experimental prescription drug that is not  
34 approved for any indication by the United States food and drug  
35 administration.  
36           3. Alter any law with regard to provisions that limit the coverage of  
37 prescription drugs that have not been approved by the United States food and  
38 drug administration.  
39           4. Notwithstanding section 20-841.05, require reimbursement or  
40 coverage for any prescription drug that is not included in the drug formulary  
41 or list of covered prescription drugs specified in the contract.  
42           5. Notwithstanding section 20-841.05, prohibit a contract from  
43 limiting or excluding coverage of a prescription drug, if the decision to  
44 limit or exclude coverage of the prescription drug is not based primarily on  
45 the coverage of prescription drugs required by this section.

6. Prohibit the use of deductibles, coinsurance, copayments or other cost sharing in relation to drug benefits and related medical benefits offered.

S. For the purposes of subsection R of this section:

1. The acceptable standard medical reference compendia are the following:

~~(a) The American medical association drug evaluations, a publication of the American medical association.~~

~~(b)~~ (a) The American hospital formulary service drug information, a publication of the American society of health system pharmacists.

~~(c) Drug information for the health care provider, a publication of the United States pharmacopoeia convention.~~

(b) THE NATIONAL COMPREHENSIVE CANCER NETWORK DRUGS AND BIOLOGICS COMPENDIUM.

(c) THOMSON MICROMEDEX COMPENDIUM DRUGDEX.

(d) ELSEVIER GOLD STANDARD'S CLINICAL PHARMACOLOGY COMPENDIUM.

(e) OTHER AUTHORITATIVE COMPENDIA AS IDENTIFIED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

2. Medical literature may be accepted if all of the following apply:

(a) At least two articles from major peer reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.

(b) No article from a major peer reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.

(c) The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States department of health and human services as acceptable peer reviewed medical literature pursuant to section 186(t)(2)(B) of the social security act (42 United States Code section 1395x(t)(2)(B)).

T. A corporation shall not issue or deliver any advertising matter or sales material to any person in this state until the corporation files the advertising matter or sales material with the director. This subsection does not require a corporation to have the prior approval of the director to issue or deliver the advertising matter or sales material. If the director finds that the advertising matter or sales material, in whole or in part, is false, deceptive or misleading, the director may issue an order disapproving the advertising matter or sales material, directing the corporation to cease and desist from issuing, circulating, displaying or using the advertising matter or sales material within a period of time specified by the director but not less than ten days and imposing any penalties prescribed in this title. At

1 least five days before issuing an order pursuant to this subsection, the  
2 director shall provide the corporation with a written notice of the basis of  
3 the order to provide the corporation with an opportunity to cure the alleged  
4 deficiency in the advertising matter or sales material within a single five  
5 day period for the particular advertising matter or sales material at issue.  
6 The corporation may appeal the director's order pursuant to title 41, chapter  
7 6, article 10. Except as otherwise provided in this subsection, a  
8 corporation may obtain a stay of the effectiveness of the order as prescribed  
9 in section 20-162. If the director certifies in the order and provides a  
10 detailed explanation of the reasons in support of the certification that  
11 continued use of the advertising matter or sales material poses a threat to  
12 the health, safety or welfare of the public, the order may be entered  
13 immediately without opportunity for cure and the effectiveness of the order  
14 is not stayed pending the hearing on the notice of appeal but the hearing  
15 shall be promptly instituted and determined.

16 U. Any contract that is offered by a hospital service corporation or  
17 medical service corporation and that contains a prescription drug benefit  
18 shall provide coverage of medical foods to treat inherited metabolic  
19 disorders as provided by this section.

20 V. The metabolic disorders triggering medical foods coverage under  
21 this section shall:

22 1. Be part of the newborn screening program prescribed in section  
23 36-694.

24 2. Involve amino acid, carbohydrate or fat metabolism.

25 3. Have medically standard methods of diagnosis, treatment and  
26 monitoring including quantification of metabolites in blood, urine or spinal  
27 fluid or enzyme or DNA confirmation in tissues.

28 4. Require specially processed or treated medical foods that are  
29 generally available only under the supervision and direction of a physician  
30 who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse  
31 ~~practitioners~~ PRACTITIONER who is licensed pursuant to title 32, chapter 15,  
32 that must be consumed throughout life and without which the person may suffer  
33 serious mental or physical impairment.

34 W. Medical foods eligible for coverage under this section shall be  
35 prescribed or ordered under the supervision of a physician licensed pursuant  
36 to title 32, chapter 13 or 17 as medically necessary for the therapeutic  
37 treatment of an inherited metabolic disease.

38 X. A hospital service corporation or medical service corporation shall  
39 cover at least fifty per cent of the cost of medical foods prescribed to  
40 treat inherited metabolic disorders and covered pursuant to this section. A  
41 hospital service corporation or medical service corporation may limit the  
42 maximum annual benefit for medical foods under this section to five thousand  
43 dollars, which applies to the cost of all prescribed modified low protein  
44 foods and metabolic formula.



1           Y. Any contract between a corporation and its subscribers is subject  
2 to the following:

3           1. If the contract provides coverage for prescription drugs, the  
4 contract shall provide coverage for any prescribed drug or device that is  
5 approved by the United States food and drug administration for use as a  
6 contraceptive. A corporation may use a drug formulary, multitiered drug  
7 formulary or list but that formulary or list shall include oral, implant and  
8 injectable contraceptive drugs, intrauterine devices and prescription barrier  
9 methods if the corporation does not impose deductibles, coinsurance,  
10 copayments or other cost containment measures for contraceptive drugs that  
11 are greater than the deductibles, coinsurance, copayments or other cost  
12 containment measures for other drugs on the same level of the formulary or  
13 list.

14           2. If the contract provides coverage for outpatient health care  
15 services, the contract shall provide coverage for outpatient contraceptive  
16 services. For the purposes of this paragraph, "outpatient contraceptive  
17 services" means consultations, examinations, procedures and medical services  
18 provided on an outpatient basis and related to the use of approved United  
19 States food and drug administration prescription contraceptive methods to  
20 prevent unintended pregnancies.

21           3. This subsection does not apply to contracts issued to individuals  
22 on a nongroup basis.

23           Z. Notwithstanding subsection Y of this section, a religious employer  
24 whose religious tenets prohibit the use of prescribed contraceptive methods  
25 may require that the corporation provide a contract without coverage for all  
26 United States food and drug administration approved contraceptive methods. A  
27 religious employer shall submit a written affidavit to the corporation  
28 stating that it is a religious employer. On receipt of the affidavit, the  
29 corporation shall issue to the religious employer a contract that excludes  
30 coverage of prescription contraceptive methods. The corporation shall retain  
31 the affidavit for the duration of the contract and any renewals of the  
32 contract. Before enrollment in the plan, every religious employer that  
33 invokes this exemption shall provide prospective subscribers written notice  
34 that the religious employer refuses to cover all United States food and drug  
35 administration approved contraceptive methods for religious reasons. This  
36 subsection shall not exclude coverage for prescription contraceptive methods  
37 ordered by a health care provider with prescriptive authority for medical  
38 indications other than to prevent an unintended pregnancy. A corporation may  
39 require the subscriber to first pay for the prescription and then submit a  
40 claim to the corporation along with evidence that the prescription is for a  
41 noncontraceptive purpose. A corporation may charge an administrative fee for  
42 handling these claims. A religious employer shall not discriminate against  
43 an employee who independently chooses to obtain insurance coverage or  
44 prescriptions for contraceptives from another source.

1 AA. For the purposes of:

2 1. This section:

3 (a) "Inherited metabolic disorder" means a disease caused by an  
4 inherited abnormality of body chemistry and includes a disease tested under  
5 the newborn screening program prescribed in section 36-694.

6 (b) "Medical foods" means modified low protein foods and metabolic  
7 formula.

8 (c) "Metabolic formula" means foods that are all of the following:

9 (i) Formulated to be consumed or administered enterally under the  
10 supervision of a physician who is licensed pursuant to title 32, chapter 13  
11 or 17.

12 (ii) Processed or formulated to be deficient in one or more of the  
13 nutrients present in typical foodstuffs.

14 (iii) Administered for the medical and nutritional management of a  
15 person who has limited capacity to metabolize foodstuffs or certain nutrients  
16 contained in the foodstuffs or who has other specific nutrient requirements  
17 as established by medical evaluation.

18 (iv) Essential to a person's optimal growth, health and metabolic  
19 homeostasis.

20 (d) "Modified low protein foods" means foods that are all of the  
21 following:

22 (i) Formulated to be consumed or administered enterally under the  
23 supervision of a physician who is licensed pursuant to title 32, chapter 13  
24 or 17.

25 (ii) Processed or formulated to contain less than one gram of protein  
26 per unit of serving, but does not include a natural food that is naturally  
27 low in protein.

28 (iii) Administered for the medical and nutritional management of a  
29 person who has limited capacity to metabolize foodstuffs or certain nutrients  
30 contained in the foodstuffs or who has other specific nutrient requirements  
31 as established by medical evaluation.

32 (iv) Essential to a person's optimal growth, health and metabolic  
33 homeostasis.

34 2. Subsection E of this section, the term "child", for purposes of  
35 initial coverage of an adopted child or a child placed for adoption but not  
36 for purposes of termination of coverage of such child, means a person under  
37 the age of eighteen years.

38 3. Subsection Z of this section, "religious employer" means an entity  
39 for which all of the following apply:

40 (a) The entity primarily employs persons who share the religious  
41 tenets of the entity.

42 (b) The entity primarily serves persons who share the religious tenets  
43 of the entity.

44 (c) The entity is a nonprofit organization as described in section  
45 6033(a)(2)(A) (i) or (iii) of the internal revenue code of 1986, as amended.

Sec. 2. Section 20-1057, Arizona Revised Statutes, is amended to read:  
20-1057. Evidence of coverage by health care services  
organizations; renewability; definitions

A. Every enrollee in a health care plan shall be issued an evidence of coverage by the responsible health care services organization.

B. Any contract, except accidental death and dismemberment, applied for that provides family coverage shall also provide, as to such coverage of family members, that the benefits applicable for children shall be payable with respect to a newly born child of the enrollee from the instant of such child's birth, to a child adopted by the enrollee, regardless of the age at which the child was adopted, and to a child who has been placed for adoption with the enrollee and for whom the application and approval procedures for adoption pursuant to section 8-105 or 8-108 have been completed to the same extent that such coverage applies to other members of the family. The coverage for newly born or adopted children or children placed for adoption shall include coverage of injury or sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the contract may require that notification of birth, adoption or adoption placement of the child and payment of the required premium must be furnished to the insurer within thirty-one days after the date of birth, adoption or adoption placement in order to have the coverage continue beyond the thirty-one day period.

C. Any contract, except accidental death and dismemberment, that provides coverage for psychiatric, drug abuse or alcoholism services shall require the health care services organization to provide reimbursement for such services in accordance with the terms of the contract without regard to whether the covered services are rendered in a psychiatric special hospital or general hospital.

D. No evidence of coverage or amendment to the coverage shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage or amendment to the coverage has been filed with and approved by the director.

E. An evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate of contract, of:

1. The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan.

2. Any limitations of the services, kind of services, benefits or kind of benefits to be provided, including any deductible or copayment feature.

3. Where and in what manner information is available as to how services may be obtained.

4. The enrollee's obligation, if any, respecting charges for the health care plan.

1 F. An evidence of coverage shall not contain provisions or statements  
2 that are unjust, unfair, inequitable, misleading or deceptive, that encourage  
3 misrepresentation or that are untrue.

4 G. The director shall approve any form of evidence of coverage if the  
5 requirements of subsections E and F of this section are met. It is unlawful  
6 to issue such form until approved. If the director does not disapprove any  
7 such form within forty-five days after the filing of the form, it is deemed  
8 approved. If the director disapproves a form of evidence of coverage, the  
9 director shall notify the health care services organization. In the notice,  
10 the director shall specify the reasons for the director's disapproval. The  
11 director shall grant a hearing on such disapproval within fifteen days after  
12 a request for a hearing in writing is received from the health care services  
13 organization.

14 H. A health care services organization shall not cancel or refuse to  
15 renew an enrollee's evidence of coverage that was issued on a group basis  
16 without giving notice of the cancellation or nonrenewal to the enrollee and,  
17 on request of the director, to the department of insurance. A notice by the  
18 organization to the enrollee of cancellation or nonrenewal of the enrollee's  
19 evidence of coverage shall be mailed to the enrollee at least sixty days  
20 before the effective date of such cancellation or nonrenewal. The notice  
21 shall include or be accompanied by a statement in writing of the reasons as  
22 stated in the contract for such action by the organization. Failure of the  
23 organization to comply with this subsection shall invalidate any cancellation  
24 or nonrenewal except a cancellation or nonrenewal for nonpayment of premium,  
25 for fraud or misrepresentation in the application or other enrollment  
26 documents or for loss of eligibility as defined in the evidence of coverage.  
27 A health care services organization shall not cancel an enrollee's evidence  
28 of coverage issued on a group basis because of the enrollee's or dependent's  
29 age, except for loss of eligibility as defined in the evidence of coverage,  
30 sex, health status-related factor, national origin or frequency of  
31 utilization of health care services of the enrollee. An evidence of coverage  
32 issued on a group basis shall clearly delineate all terms under which the  
33 health care services organization may cancel or refuse to renew an evidence  
34 of coverage for an enrollee or dependent. Nothing in this subsection  
35 prohibits the cancellation or nonrenewal of a health benefits plan contract  
36 issued on a group basis for any of the reasons allowed in section 20-2309. A  
37 health care services organization may cancel or nonrenew an evidence of  
38 coverage issued to an individual on a nongroup basis only for the reasons  
39 allowed by subsection N of this section.

40 I. A health care plan that provides coverage for surgical services for  
41 a mastectomy shall also provide coverage incidental to the patient's covered  
42 mastectomy for surgical services for reconstruction of the breast on which  
43 the mastectomy was performed, surgery and reconstruction of the other breast  
44 to produce a symmetrical appearance, prostheses, treatment of physical  
45 complications for all stages of the mastectomy, including lymphedemas, and at

1 least two external postoperative prostheses subject to all of the terms and  
2 conditions of the policy.

3 J. A contract that provides coverage for surgical services for a  
4 mastectomy shall also provide coverage for mammography screening performed on  
5 dedicated equipment for diagnostic purposes on referral by a patient's  
6 physician, subject to all of the terms and conditions of the policy and  
7 according to the following guidelines:

8 1. A baseline mammogram for a woman from age thirty-five to  
9 thirty-nine.

10 2. A mammogram for a woman from age forty to forty-nine every two  
11 years or more frequently based on the recommendation of the woman's  
12 physician.

13 3. A mammogram every year for a woman fifty years of age and over.

14 K. Any contract that is issued to the enrollee and that provides  
15 coverage for maternity benefits shall also provide that the maternity  
16 benefits apply to the costs of the birth of any child legally adopted by the  
17 enrollee if all the following are true:

18 1. The child is adopted within one year of birth.

19 2. The enrollee is legally obligated to pay the costs of birth.

20 3. All preexisting conditions and other limitations have been met and  
21 all deductibles and copayments have been paid by the enrollee.

22 4. The enrollee has notified the insurer of the enrollee's  
23 acceptability to adopt children pursuant to section 8-105 within sixty days  
24 after such approval or within sixty days after a change in insurance  
25 policies, plans or companies.

26 L. The coverage prescribed by subsection K of this section is excess  
27 to any other coverage the natural mother may have for maternity benefits  
28 except coverage made available to persons pursuant to title 36, chapter 29  
29 but not including coverage made available to persons defined as eligible  
30 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If  
31 such other coverage exists the agency, attorney or individual arranging the  
32 adoption shall make arrangements for the insurance to pay those costs that  
33 may be covered under that policy and shall advise the adopting parent in  
34 writing of the existence and extent of the coverage without disclosing any  
35 confidential information such as the identity of the natural parent. The  
36 enrollee adopting parents shall notify their health care services  
37 organization of the existence and extent of the other coverage. A health  
38 care services organization is not required to pay any costs in excess of the  
39 amounts it would have been obligated to pay to its hospitals and providers if  
40 the natural mother and child had received the maternity and newborn care  
41 directly from or through that health care services organization.

42 M. Each health care services organization shall offer membership to  
43 the following in a conversion plan that provides the basic health care  
44 benefits required by the director:

1           1. Each enrollee including the enrollee's enrolled dependents leaving  
2 a group.

3           2. Each enrollee and the enrollee's dependents who would otherwise  
4 cease to be eligible for membership because of the age of the enrollee or the  
5 enrollee's dependents or the death or the dissolution of marriage of an  
6 enrollee.

7           N. A health care services organization shall not cancel or nonrenew an  
8 evidence of coverage issued to an individual on a nongroup basis, including a  
9 conversion plan, except for any of the following reasons and in compliance  
10 with the notice and disclosure requirements contained in subsection H of this  
11 section:

12           1. The individual has failed to pay premiums or contributions in  
13 accordance with the terms of the evidence of coverage or the health care  
14 services organization has not received premium payments in a timely manner.

15           2. The individual has performed an act or practice that constitutes  
16 fraud or the individual made an intentional misrepresentation of material  
17 fact under the terms of the evidence of coverage.

18           3. The health care services organization has ceased to offer coverage  
19 to individuals that is consistent with the requirements of sections 20-1379  
20 and 20-1380.

21           4. If the health care services organization offers a health care plan  
22 in this state through a network plan, the individual no longer resides, lives  
23 or works in the service area served by the network plan or in an area for  
24 which the health care services organization is authorized to transact  
25 business but only if the coverage is terminated uniformly without regard to  
26 any health status-related factor of the covered individual.

27           5. If the health care services organization offers health coverage in  
28 this state in the individual market only through one or more bona fide  
29 associations, the membership of the individual in the association has ceased  
30 but only if that coverage is terminated uniformly without regard to any  
31 health status-related factor of any covered individual.

32           O. A conversion plan may be modified if the modification complies with  
33 the notice and disclosure provisions for cancellation and nonrenewal under  
34 subsection H of this section. A modification of a conversion plan that has  
35 already been issued shall not result in the effective elimination of any  
36 benefit originally included in the conversion plan.

37           P. Any person who is a United States armed forces reservist, who is  
38 ordered to active military duty on or after August 22, 1990 and who was  
39 enrolled in a health care plan shall have the right to reinstate such  
40 coverage upon release from active military duty subject to the following  
41 conditions:

42           1. The reservist shall make written application to the health plan  
43 within ninety days of discharge from active military duty or within one year  
44 of hospitalization continuing after discharge. Coverage shall be effective  
45 upon receipt of the application by the health plan.

2. The health plan may exclude from such coverage any health or physical condition arising during and occurring as a direct result of active military duty.

Q. The director shall adopt emergency rules **THAT ARE** applicable to persons who are leaving active service in the armed forces of the United States and returning to civilian status consistent with subsection P of this section ~~including~~ **AND THAT INCLUDE:**

1. Conditions of eligibility.
2. Coverage of dependents.
3. Preexisting conditions.
4. Termination of insurance.
5. Probationary periods.
6. Limitations.
7. Exceptions.
8. Reductions.
9. Elimination periods.
10. Requirements for replacement.
11. Any other conditions of evidences of coverage.

R. Any contract that provides maternity benefits shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight hours following a normal vaginal delivery or ninety-six hours following a cesarean section. The contract shall not require the provider to obtain authorization from the health care services organization for prescribing the minimum length of stay required by this subsection. The contract may provide that an attending provider in consultation with the mother may discharge the mother or the newborn child before the expiration of the minimum length of stay required by this subsection. The health care services organization shall not:

1. Deny the mother or the newborn child eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract solely for the purpose of avoiding the requirements of this subsection.

2. Provide monetary payments or rebates to mothers to encourage those mothers to accept less than the minimum protections available pursuant to this subsection.

3. Penalize or otherwise reduce or limit the reimbursement of an attending provider because that provider provided care to any insured under the contract in accordance with this subsection.

4. Provide monetary or other incentives to an attending provider to induce that provider to provide care to an insured under the contract in a manner that is inconsistent with this subsection.

5. Except as described in subsection S of this section, restrict benefits for any portion of a period within the minimum length of stay in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

S. Nothing in subsection R of this section:

1           1. Requires a mother to give birth in a hospital or to stay in the  
2 hospital for a fixed period of time following the birth of the child.

3           2. Prevents a health care services organization from imposing  
4 deductibles, coinsurance or other cost sharing in relation to benefits for  
5 hospital lengths of stay in connection with childbirth for a mother or a  
6 newborn child under the contract, except that any coinsurance or other cost  
7 sharing for any portion of a period within a hospital length of stay required  
8 pursuant to subsection R of this section shall not be greater than the  
9 coinsurance or cost sharing for any preceding portion of that stay.

10          3. Prevents a health care services organization from negotiating the  
11 level and type of reimbursement with a provider for care provided in  
12 accordance with subsection R of this section.

13          T. Any contract or evidence of coverage that provides coverage for  
14 diabetes shall also provide coverage for equipment and supplies that are  
15 medically necessary and that are prescribed by a health care provider  
16 including:

- 17           1. Blood glucose monitors.
- 18           2. Blood glucose monitors for the legally blind.
- 19           3. Test strips for glucose monitors and visual reading and urine  
20 testing strips.
- 21           4. Insulin preparations and glucagon.
- 22           5. Insulin cartridges.
- 23           6. Drawing up devices and monitors for the visually impaired.
- 24           7. Injection aids.
- 25           8. Insulin cartridges for the legally blind.
- 26           9. Syringes and lancets including automatic lancing devices.
- 27           10. Prescribed oral agents for controlling blood sugar that are  
28 included on the plan formulary.
- 29           11. To the extent coverage is required under medicare, podiatric  
30 appliances for prevention of complications associated with diabetes.
- 31           12. Any other device, medication, equipment or supply for which  
32 coverage is required under medicare from and after January 1, 1999. The  
33 coverage required in this paragraph is effective six months after the  
34 coverage is required under medicare.

35          U. Nothing in subsection T of this section:

36           1. Entitles a member or enrollee of a health care services  
37 organization to equipment or supplies for the treatment of diabetes that are  
38 not medically necessary as determined by the health care services  
39 organization medical director or the medical director's designee.

40           2. Provides coverage for diabetic supplies obtained by a member or  
41 enrollee of a health care services organization without a prescription unless  
42 otherwise permitted pursuant to the terms of the health care plan.

43           3. Prohibits a health care services organization from imposing  
44 deductibles, coinsurance or other cost sharing in relation to benefits for  
45 equipment or supplies for the treatment of diabetes.



V. Any contract or evidence of coverage that provides coverage for prescription drugs shall not limit or exclude coverage for any prescription drug prescribed for the treatment of cancer on the basis that the prescription drug has not been approved by the United States food and drug administration for the treatment of the specific type of cancer for which the prescription drug has been prescribed, if the prescription drug has been recognized as safe and effective for treatment of that specific type of cancer in one or more of the standard medical reference compendia prescribed in subsection W of this section or medical literature that meets the criteria prescribed in subsection W of this section. The coverage required under this subsection includes covered medically necessary services associated with the administration of the prescription drug. This subsection does not:

1. Require coverage of any prescription drug used in the treatment of a type of cancer if the United States food and drug administration has determined that the prescription drug is contraindicated for that type of cancer.

2. Require coverage for any experimental prescription drug that is not approved for any indication by the United States food and drug administration.

3. Alter any law with regard to provisions that limit the coverage of prescription drugs that have not been approved by the United States food and drug administration.

4. Notwithstanding section 20-1057.02, require reimbursement or coverage for any prescription drug that is not included in the drug formulary or list of covered prescription drugs specified in the contract or evidence of coverage.

5. Notwithstanding section 20-1057.02, prohibit a contract or evidence of coverage from limiting or excluding coverage of a prescription drug, if the decision to limit or exclude coverage of the prescription drug is not based primarily on the coverage of prescription drugs required by this section.

6. Prohibit the use of deductibles, coinsurance, copayments or other cost sharing in relation to drug benefits and related medical benefits offered.

W. For the purposes of subsection V of this section:

1. The acceptable standard medical reference compendia are the following:

~~(a) The American medical association drug evaluations, a publication of the American medical association.~~

~~(b)~~ (a) The American hospital formulary service drug information, a publication of the American society of health system pharmacists.

~~(c) Drug information for the health care provider, a publication of the United States pharmacopoeia convention.~~

(b) THE NATIONAL COMPREHENSIVE CANCER NETWORK DRUGS AND BIOLOGICS COMPENDIUM.

- 1 (c) THOMSON MICROMEDEX COMPENDIUM DRUGDEX.
- 2 (d) ELSEVIER GOLD STANDARD'S CLINICAL PHARMACOLOGY COMPENDIUM.
- 3 (e) OTHER AUTHORITATIVE COMPENDIA AS IDENTIFIED BY THE SECRETARY OF
- 4 THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

5 2. Medical literature may be accepted if all of the following apply:

6 (a) At least two articles from major peer reviewed professional  
 7 medical journals have recognized, based on scientific or medical criteria,  
 8 the drug's safety and effectiveness for treatment of the indication for which  
 9 the drug has been prescribed.

10 (b) No article from a major peer reviewed professional medical journal  
 11 has concluded, based on scientific or medical criteria, that the drug is  
 12 unsafe or ineffective or that the drug's safety and effectiveness cannot be  
 13 determined for the treatment of the indication for which the drug has been  
 14 prescribed.

15 (c) The literature meets the uniform requirements for manuscripts  
 16 submitted to biomedical journals established by the international committee  
 17 of medical journal editors or is published in a journal specified by the  
 18 United States department of health and human services as acceptable peer  
 19 reviewed medical literature pursuant to section 186(t)(2)(B) of the social  
 20 security act (42 United States Code section 1395x(t)(2)(B)).

21 X. A health care services organization shall not issue or deliver any  
 22 advertising matter or sales material to any person in this state until the  
 23 health care services organization files the advertising matter or sales  
 24 material with the director. This subsection does not require a health care  
 25 services organization to have the prior approval of the director to issue or  
 26 deliver the advertising matter or sales material. If the director finds that  
 27 the advertising matter or sales material, in whole or in part, is false,  
 28 deceptive or misleading, the director may issue an order disapproving the  
 29 advertising matter or sales material, directing the health care services  
 30 organization to cease and desist from issuing, circulating, displaying or  
 31 using the advertising matter or sales material within a period of time  
 32 specified by the director but not less than ten days and imposing any  
 33 penalties prescribed in this title. At least five days before issuing an  
 34 order pursuant to this subsection, the director shall provide the health care  
 35 services organization with a written notice of the basis of the order to  
 36 provide the health care services organization with an opportunity to cure the  
 37 alleged deficiency in the advertising matter or sales material within a  
 38 single five day period for the particular advertising matter or sales  
 39 material at issue. The health care services organization may appeal the  
 40 director's order pursuant to title 41, chapter 6, article 10. Except as  
 41 otherwise provided in this subsection, a health care services organization  
 42 may obtain a stay of the effectiveness of the order as prescribed in section  
 43 20-162. If the director certifies in the order and provides a detailed  
 44 explanation of the reasons in support of the certification that continued use  
 45 of the advertising matter or sales material poses a threat to the health,

safety or welfare of the public, the order may be entered immediately without opportunity for cure and the effectiveness of the order is not stayed pending the hearing on the notice of appeal but the hearing shall be promptly instituted and determined.

Y. Any contract or evidence of coverage that is offered by a health care services organization and that contains a prescription drug benefit shall provide coverage of medical foods to treat inherited metabolic disorders as provided by this section.

Z. The metabolic disorders triggering medical foods coverage under this section shall:

1. Be part of the newborn screening program prescribed in section 36-694.

2. Involve amino acid, carbohydrate or fat metabolism.

3. Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues.

4. Require specially processed or treated medical foods that are generally available only under the supervision and direction of a physician who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse practitioner who is licensed pursuant to title 32, chapter 15, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

AA. Medical foods eligible for coverage under this section shall be prescribed or ordered under the supervision of a physician licensed pursuant to title 32, chapter 13 or 17 or a registered nurse practitioner who is licensed pursuant to title 32, chapter 15 as medically necessary for the therapeutic treatment of an inherited metabolic disease.

BB. A health care services organization shall cover at least fifty per cent of the cost of medical foods prescribed to treat inherited metabolic disorders and covered pursuant to this section. An organization may limit the maximum annual benefit for medical foods under this section to five thousand dollars, which applies to the cost of all prescribed modified low protein foods and metabolic formula.

CC. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

DD. For the purposes of:

1. This section:

(a) "Inherited metabolic disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program prescribed in section 36-694.

(b) "Medical foods" means modified low protein foods and metabolic formula.

(c) "Metabolic formula" means foods that are all of the following:

1 (i) Formulated to be consumed or administered enterally under the  
2 supervision of a physician who is licensed pursuant to title 32, chapter 13  
3 or 17 or a registered nurse practitioner who is licensed pursuant to title  
4 32, chapter 15.

5 (ii) Processed or formulated to be deficient in one or more of the  
6 nutrients present in typical foodstuffs.

7 (iii) Administered for the medical and nutritional management of a  
8 person who has limited capacity to metabolize foodstuffs or certain nutrients  
9 contained in the foodstuffs or who has other specific nutrient requirements  
10 as established by medical evaluation.

11 (iv) Essential to a person's optimal growth, health and metabolic  
12 homeostasis.

13 (d) "Modified low protein foods" means foods that are all of the  
14 following:

15 (i) Formulated to be consumed or administered enterally under the  
16 supervision of a physician who is licensed pursuant to title 32, chapter 13  
17 or 17 or a registered nurse practitioner who is licensed pursuant to title  
18 32, chapter 15.

19 (ii) Processed or formulated to contain less than one gram of protein  
20 per unit of serving, but does not include a natural food that is naturally  
21 low in protein.

22 (iii) Administered for the medical and nutritional management of a  
23 person who has limited capacity to metabolize foodstuffs or certain nutrients  
24 contained in the foodstuffs or who has other specific nutrient requirements  
25 as established by medical evaluation.

26 (iv) Essential to a person's optimal growth, health and metabolic  
27 homeostasis.

28 2. Subsection B of this section, "child", for purposes of initial  
29 coverage of an adopted child or a child placed for adoption but not for  
30 purposes of termination of coverage of such child, means a person under ~~the~~  
31 ~~age of~~ eighteen years **OF AGE**.

32 Sec. 3. Section 20-1342, Arizona Revised Statutes, is amended to read:  
33 **20-1342. Scope and format of policy; definitions**

34 A. A policy of disability insurance shall not be delivered or issued  
35 for delivery to any person in this state unless it otherwise complies with  
36 this title and complies with the following:

37 1. The entire money and other considerations shall be expressed in the  
38 policy.

39 2. The time when the insurance takes effect and terminates shall be  
40 expressed in the policy.

41 3. It shall purport to insure only one person, except that a policy  
42 may insure, originally or by subsequent amendment, on the application of the  
43 policyholder or the policyholder's spouse, any two or more eligible members  
44 of that family, including husband, wife, dependent children or any children  
45 under a specified age that does not exceed nineteen years and any other

1 person dependent upon the policyholder. Any policy, except accidental death  
2 and dismemberment, applied for that provides family coverage shall, as to  
3 such coverage of family members, **SHALL** also provide that the benefits  
4 applicable for children shall be payable with respect to a newly born child  
5 of the insured from the instant of such child's birth, to a child adopted by  
6 the insured, regardless of the age at which the child was adopted, and to a  
7 child who has been placed for adoption with the insured and for whom the  
8 application and approval procedures for adoption pursuant to section 8-105 or  
9 8-108 have been completed to the same extent that such coverage applies to  
10 other members of the family. The coverage for newly born or adopted children  
11 or children placed for adoption shall include coverage of injury or sickness  
12 including necessary care and treatment of medically diagnosed congenital  
13 defects and birth abnormalities. If payment of a specific premium is  
14 required to provide coverage for a child, the policy may require that  
15 notification of birth, adoption or adoption placement of the child and  
16 payment of the required premium must be furnished to the insurer within  
17 thirty-one days after the date of birth, adoption or adoption placement in  
18 order to have the coverage continue beyond the thirty-one day period.

19 4. The style, arrangement and overall appearance of the policy shall  
20 give no undue prominence to any portion of the text, and every printed  
21 portion of the text of the policy and of any endorsements or attached papers  
22 shall be plainly printed in light-faced type of a style in general use, the  
23 size of which shall be uniform and not less than ten point with a lower case  
24 unspaced alphabet length of not less than one hundred and twenty point.  
25 "Text" shall include all printed matter except the name and address of the  
26 insurer, name or title of the policy, the brief description, if any, and  
27 captions and subcaptions.

28 5. The exceptions and reductions of indemnity shall be set forth in  
29 the policy and, other than those contained in sections 20-1345 through  
30 20-1368, shall be printed and, at the insurer's option, either included with  
31 the benefit provision to which they apply or under an appropriate caption  
32 such as "exceptions", or "exceptions and reductions", except that if an  
33 exception or reduction specifically applies only to a particular benefit of  
34 the policy, a statement of such exception or reduction shall be included with  
35 the benefit provision to which it applies.

36 6. Each such form, including riders and endorsements, shall be  
37 identified by a form number in the lower left-hand corner of the first page.

38 7. The policy shall contain no provision purporting to make any  
39 portion of the charter, rules, constitution or bylaws of the insurer a part  
40 of the policy unless such portion is set forth in full in the policy, except  
41 in the case of the incorporation of, or reference to, a statement of rates or  
42 classification of risks, or short-rate table filed with the director.

43 8. Each contract shall be so written that the corporation shall pay  
44 benefits:

1 (a) For performance of any surgical service that is covered by the  
2 terms of such contract, regardless of the place of service.

3 (b) For any home health services that are performed by a licensed home  
4 health agency and that a physician has prescribed in lieu of hospital  
5 services, as defined by the director, providing the hospital services would  
6 have been covered.

7 (c) For any diagnostic service that a physician has performed outside  
8 a hospital in lieu of inpatient service, providing the inpatient service  
9 would have been covered.

10 (d) For any service performed in a hospital's outpatient department or  
11 in a freestanding surgical facility, providing such service would have been  
12 covered if performed as an inpatient service.

13 9. A disability insurance policy that provides coverage for the  
14 surgical expense of a mastectomy shall also provide coverage incidental to  
15 the patient's covered mastectomy for the expense of reconstructive surgery of  
16 the breast on which the mastectomy was performed, surgery and reconstruction  
17 of the other breast to produce a symmetrical appearance, prostheses,  
18 treatment of physical complications for all stages of the mastectomy,  
19 including lymphedemas, and at least two external postoperative prostheses  
20 subject to all of the terms and conditions of the policy.

21 10. A contract, except a supplemental contract covering a specified  
22 disease or other limited benefits, that provides coverage for surgical  
23 services for a mastectomy shall also provide coverage for mammography  
24 screening performed on dedicated equipment for diagnostic purposes on  
25 referral by a patient's physician, subject to all of the terms and conditions  
26 of the policy and according to the following guidelines:

27 (a) A baseline mammogram for a woman from age thirty-five to  
28 thirty-nine.

29 (b) A mammogram for a woman from age forty to forty-nine every two  
30 years or more frequently based on the recommendation of the woman's  
31 physician.

32 (c) A mammogram every year for a woman fifty years of age and over.

33 11. Any contract that is issued to the insured and that provides  
34 coverage for maternity benefits shall also provide that the maternity  
35 benefits apply to the costs of the birth of any child legally adopted by the  
36 insured if all the following are true:

37 (a) The child is adopted within one year of birth.

38 (b) The insured is legally obligated to pay the costs of birth.

39 (c) All preexisting conditions and other limitations have been met by  
40 the insured.

41 (d) The insured has notified the insurer of the insured's  
42 acceptability to adopt children pursuant to section 8-105, within sixty days  
43 after such approval or within sixty days after a change in insurance  
44 policies, plans or companies.

1        12. The coverage prescribed by paragraph 11 of this subsection is  
2 excess to any other coverage the natural mother may have for maternity  
3 benefits except coverage made available to persons pursuant to title 36,  
4 chapter 29, but not including coverage made available to persons defined as  
5 eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d)  
6 and (e). If such other coverage exists the agency, attorney or individual  
7 arranging the adoption shall make arrangements for the insurance to pay those  
8 costs that may be covered under that policy and shall advise the adopting  
9 parent in writing of the existence and extent of the coverage without  
10 disclosing any confidential information such as the identity of the natural  
11 parent. The insured adopting parents shall notify their insurer of the  
12 existence and extent of the other coverage.

13        B. Any contract that provides maternity benefits shall not restrict  
14 benefits for any hospital length of stay in connection with childbirth for  
15 the mother or the newborn child to less than forty-eight hours following a  
16 normal vaginal delivery or ninety-six hours following a cesarean section.  
17 The contract shall not require the provider to obtain authorization from the  
18 insurer for prescribing the minimum length of stay required by this  
19 subsection. The contract may provide that an attending provider in  
20 consultation with the mother may discharge the mother or the newborn child  
21 before the expiration of the minimum length of stay required by this  
22 subsection. The insurer shall not:

23        1. Deny the mother or the newborn child eligibility or continued  
24 eligibility to enroll or to renew coverage under the terms of the contract  
25 solely for the purpose of avoiding the requirements of this subsection.

26        2. Provide monetary payments or rebates to mothers to encourage those  
27 mothers to accept less than the minimum protections available pursuant to  
28 this subsection.

29        3. Penalize or otherwise reduce or limit the reimbursement of an  
30 attending provider because that provider provided care to any insured under  
31 the contract in accordance with this subsection.

32        4. Provide monetary or other incentives to an attending provider to  
33 induce that provider to provide care to an insured under the contract in a  
34 manner that is inconsistent with this subsection.

35        5. Except as described in subsection C of this section, restrict  
36 benefits for any portion of a period within the minimum length of stay in a  
37 manner that is less favorable than the benefits provided for any preceding  
38 portion of that stay.

39        C. Nothing in subsection B of this section:

40        1. Requires a mother to give birth in a hospital or to stay in the  
41 hospital for a fixed period of time following the birth of the child.

42        2. Prevents an insurer from imposing deductibles, coinsurance or other  
43 cost sharing in relation to benefits for hospital lengths of stay in  
44 connection with childbirth for a mother or a newborn child under the  
45 contract, except that any coinsurance or other cost sharing for any portion

1 of a period within a hospital length of stay required pursuant to subsection  
2 B of this section shall not be greater than the coinsurance or cost sharing  
3 for any preceding portion of that stay.

4 3. Prevents an insurer from negotiating the level and type of  
5 reimbursement with a provider for care provided in accordance with subsection  
6 B of this section.

7 D. Any contract that provides coverage for diabetes shall also provide  
8 coverage for equipment and supplies that are medically necessary and that are  
9 prescribed by a health care provider including:

- 10 1. Blood glucose monitors.
- 11 2. Blood glucose monitors for the legally blind.
- 12 3. Test strips for glucose monitors and visual reading and urine  
13 testing strips.
- 14 4. Insulin preparations and glucagon.
- 15 5. Insulin cartridges.
- 16 6. Drawing up devices and monitors for the visually impaired.
- 17 7. Injection aids.
- 18 8. Insulin cartridges for the legally blind.
- 19 9. Syringes and lancets including automatic lancing devices.
- 20 10. Prescribed oral agents for controlling blood sugar that are  
21 included on the plan formulary.
- 22 11. To the extent coverage is required under medicare, podiatric  
23 appliances for prevention of complications associated with diabetes.
- 24 12. Any other device, medication, equipment or supply for which  
25 coverage is required under medicare from and after January 1, 1999. The  
26 coverage required in this paragraph is effective six months after the  
27 coverage is required under medicare.

28 E. Nothing in subsection D of this section:

- 29 1. Prohibits a disability insurer from imposing deductibles,  
30 coinsurance or other cost sharing in relation to benefits for equipment or  
31 supplies for the treatment of diabetes.
- 32 2. Requires a policy to provide an insured with outpatient benefits if  
33 the policy does not cover outpatient benefits.

34 F. Any contract that provides coverage for prescription drugs shall  
35 not limit or exclude coverage for any prescription drug prescribed for the  
36 treatment of cancer on the basis that the prescription drug has not been  
37 approved by the United States food and drug administration for the treatment  
38 of the specific type of cancer for which the prescription drug has been  
39 prescribed, if the prescription drug has been recognized as safe and  
40 effective for treatment of that specific type of cancer in one or more of the  
41 standard medical reference compendia prescribed in subsection G of this  
42 section or medical literature that meets the criteria prescribed in  
43 subsection G of this section. The coverage required under this subsection  
44 includes covered medically necessary services associated with the  
45 administration of the prescription drug. This subsection does not:



1           1. Require coverage of any prescription drug used in the treatment of  
2 a type of cancer if the United States food and drug administration has  
3 determined that the prescription drug is contraindicated for that type of  
4 cancer.

5           2. Require coverage for any experimental prescription drug that is not  
6 approved for any indication by the United States food and drug  
7 administration.

8           3. Alter any law with regard to provisions that limit the coverage of  
9 prescription drugs that have not been approved by the United States food and  
10 drug administration.

11          4. Require reimbursement or coverage for any prescription drug that is  
12 not included in the drug formulary or list of covered prescription drugs  
13 specified in the contract.

14          5. Prohibit a contract from limiting or excluding coverage of a  
15 prescription drug, if the decision to limit or exclude coverage of the  
16 prescription drug is not based primarily on the coverage of prescription  
17 drugs required by this section.

18          6. Prohibit the use of deductibles, coinsurance, copayments or other  
19 cost sharing in relation to drug benefits and related medical benefits  
20 offered.

21          G. For the purposes of subsection F of this section:

22           1. The acceptable standard medical reference compendia are the  
23 following:

24           ~~(a) The American medical association drug evaluations, a publication~~  
25 ~~of the American medical association.~~

26           ~~(b)~~ (a) The American hospital formulary service drug information, a  
27 publication of the American society of health system pharmacists.

28           ~~(c) Drug information for the health care provider, a publication of~~  
29 ~~the United States pharmacopoeia convention.~~

30           (b) THE NATIONAL COMPREHENSIVE CANCER NETWORK DRUGS AND BIOLOGICS  
31 COMPENDIUM.

32           (c) THOMSON MICROMEDEX COMPENDIUM DRUGDEX.

33           (d) ELSEVIER GOLD STANDARD'S CLINICAL PHARMACOLOGY COMPENDIUM.

34           (e) OTHER AUTHORITATIVE COMPENDIA AS IDENTIFIED BY THE SECRETARY OF  
35 THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

36          2. Medical literature may be accepted if all of the following apply:

37           (a) At least two articles from major peer reviewed professional  
38 medical journals have recognized, based on scientific or medical criteria,  
39 the drug's safety and effectiveness for treatment of the indication for which  
40 the drug has been prescribed.

41           (b) No article from a major peer reviewed professional medical journal  
42 has concluded, based on scientific or medical criteria, that the drug is  
43 unsafe or ineffective or that the drug's safety and effectiveness cannot be  
44 determined for the treatment of the indication for which the drug has been  
45 prescribed.

(c) The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States department of health and human services as acceptable peer reviewed medical literature pursuant to section 186(t)(2)(B) of the social security act (42 United States Code section 1395x(t)(2)(B)).

H. Any contract that is offered by a disability insurer and that contains a routine outpatient prescription drug benefit shall provide coverage of medical foods to treat inherited metabolic disorders as provided by this section.

I. The metabolic disorders triggering medical foods coverage under this section shall:

1. Be part of the newborn screening program prescribed in section 36-694.

2. Involve amino acid, carbohydrate or fat metabolism.

3. Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues.

4. Require specially processed or treated medical foods that are generally available only under the supervision and direction of a physician who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse practitioner who is licensed pursuant to title 32, chapter 15, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

J. Medical foods eligible for coverage under this section shall be prescribed or ordered under the supervision of a physician licensed pursuant to title 32, chapter 13 or 17 or a registered nurse practitioner who is licensed pursuant to title 32, chapter 15 as medically necessary for the therapeutic treatment of an inherited metabolic disease.

K. An insurer shall cover at least fifty per cent of the cost of medical foods prescribed to treat inherited metabolic disorders and covered pursuant to this section. An insurer may limit the maximum annual benefit for medical foods under this section to five thousand dollars, which applies to the cost of all prescribed modified low protein foods and metabolic formula.

L. For the purposes of:

1. This section:

(a) "Inherited metabolic disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program prescribed in section 36-694.

(b) "Medical foods" means modified low protein foods and metabolic formula.

(c) "Metabolic formula" means foods that are all of the following:

(i) Formulated to be consumed or administered enterally under the supervision of a physician who is licensed pursuant to title 32, chapter 13

1 or 17 or a registered nurse practitioner who is licensed pursuant to title  
2 32, chapter 15.

3 (ii) Processed or formulated to be deficient in one or more of the  
4 nutrients present in typical foodstuffs.

5 (iii) Administered for the medical and nutritional management of a  
6 person who has limited capacity to metabolize foodstuffs or certain nutrients  
7 contained in the foodstuffs or who has other specific nutrient requirements  
8 as established by medical evaluation.

9 (iv) Essential to a person's optimal growth, health and metabolic  
10 homeostasis.

11 (d) "Modified low protein foods" means foods that are all of the  
12 following:

13 (i) Formulated to be consumed or administered enterally under the  
14 supervision of a physician who is licensed pursuant to title 32, chapter 13  
15 or 17 or a registered nurse practitioner who is licensed pursuant to title  
16 32, chapter 15.

17 (ii) Processed or formulated to contain less than one gram of protein  
18 per unit of serving, but does not include a natural food that is naturally  
19 low in protein.

20 (iii) Administered for the medical and nutritional management of a  
21 person who has limited capacity to metabolize foodstuffs or certain nutrients  
22 contained in the foodstuffs or who has other specific nutrient requirements  
23 as established by medical evaluation.

24 (iv) Essential to a person's optimal growth, health and metabolic  
25 homeostasis.

26 2. Subsection A of this section, the term "child", for purposes of  
27 initial coverage of an adopted child or a child placed for adoption but not  
28 for purposes of termination of coverage of such child, means a person under  
29 the age of eighteen years.

30 Sec. 4. Section 20-1402, Arizona Revised Statutes, is amended to read:

31 20-1402. Provisions of group disability policies: definitions

32 A. Each group disability policy shall contain in substance the  
33 following provisions:

34 1. A provision that, in the absence of fraud, all statements made by  
35 the policyholder or by any insured person shall be deemed representations and  
36 not warranties, and that no statement made for the purpose of effecting  
37 insurance shall avoid such insurance or reduce benefits unless contained in a  
38 written instrument signed by the policyholder or the insured person, a copy  
39 of which has been furnished to the policyholder or to the person or  
40 beneficiary.

41 2. A provision that the insurer will furnish to the policyholder, for  
42 delivery to each employee or member of the insured group, an individual  
43 certificate setting forth in summary form a statement of the essential  
44 features of the insurance coverage of the employee or member and to whom  
45 benefits are payable. If dependents or family members are included in the

1 coverage additional certificates need not be issued for delivery to the  
2 dependents or family members. Any policy, except accidental death and  
3 dismemberment, applied for that provides family coverage ~~shall~~, as to such  
4 coverage of family members, **SHALL** also provide that the benefits applicable  
5 for children shall be payable with respect to a newly born child of the  
6 insured from the instant of such child's birth, to a child adopted by the  
7 insured, regardless of the age at which the child was adopted, and to a child  
8 who has been placed for adoption with the insured and for whom the  
9 application and approval procedures for adoption pursuant to section 8-105 or  
10 8-108 have been completed to the same extent that such coverage applies to  
11 other members of the family. The coverage for newly born or adopted children  
12 or children placed for adoption shall include coverage of injury or sickness  
13 including the necessary care and treatment of medically diagnosed congenital  
14 defects and birth abnormalities. If payment of a specific premium is  
15 required to provide coverage for a child, the policy may require that  
16 notification of birth, adoption or adoption placement of the child and  
17 payment of the required premium must be furnished to the insurer within  
18 thirty-one days after the date of birth, adoption or adoption placement in  
19 order to have the coverage continue beyond such thirty-one day period.

20 3. A provision that to the group originally insured may be added from  
21 time to time eligible new employees or members or dependents, as the case may  
22 be, in accordance with the terms of the policy.

23 4. Each contract shall be so written that the corporation shall pay  
24 benefits:

25 (a) For performance of any surgical service that is covered by the  
26 terms of such contract, regardless of the place of service.

27 (b) For any home health services that are performed by a licensed home  
28 health agency and that a physician has prescribed in lieu of hospital  
29 services, as defined by the director, providing the hospital services would  
30 have been covered.

31 (c) For any diagnostic service that a physician has performed outside  
32 a hospital in lieu of inpatient service, providing the inpatient service  
33 would have been covered.

34 (d) For any service performed in a hospital's outpatient department or  
35 in a freestanding surgical facility, providing such service would have been  
36 covered if performed as an inpatient service.

37 5. A group disability insurance policy that provides coverage for the  
38 surgical expense of a mastectomy shall also provide coverage incidental to  
39 the patient's covered mastectomy for the expense of reconstructive surgery of  
40 the breast on which the mastectomy was performed, surgery and reconstruction  
41 of the other breast to produce a symmetrical appearance, prostheses,  
42 treatment of physical complications for all stages of the mastectomy,  
43 including lymphedemas, and at least two external postoperative prostheses  
44 subject to all of the terms and conditions of the policy.

6. A contract, except a supplemental contract covering a specified disease or other limited benefits, that provides coverage for surgical services for a mastectomy shall also provide coverage for mammography screening performed on dedicated equipment for diagnostic purposes on referral by a patient's physician, subject to all of the terms and conditions of the policy and according to the following guidelines:

(a) A baseline mammogram for a woman from age thirty-five to thirty-nine.

(b) A mammogram for a woman from age forty to forty-nine every two years or more frequently based on the recommendation of the woman's physician.

(c) A mammogram every year for a woman fifty years of age and over.

7. Any contract that is issued to the insured and that provides coverage for maternity benefits shall also provide that the maternity benefits apply to the costs of the birth of any child legally adopted by the insured if all the following are true:

(a) The child is adopted within one year of birth.

(b) The insured is legally obligated to pay the costs of birth.

(c) All preexisting conditions and other limitations have been met by the insured.

(d) The insured has notified the insurer of the insured's acceptability to adopt children pursuant to section 8-105, within sixty days after such approval or within sixty days after a change in insurance policies, plans or companies.

8. The coverage prescribed by paragraph 7 of this subsection is excess to any other coverage the natural mother may have for maternity benefits except coverage made available to persons pursuant to title 36, chapter 29, but not including coverage made available to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If such other coverage exists the agency, attorney or individual arranging the adoption shall make arrangements for the insurance to pay those costs that may be covered under that policy and shall advise the adopting parent in writing of the existence and extent of the coverage without disclosing any confidential information such as the identity of the natural parent. The insured adopting parents shall notify their insurer of the existence and extent of the other coverage.

B. Any policy that provides maternity benefits shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight hours following a normal vaginal delivery or ninety-six hours following a cesarean section. The policy shall not require the provider to obtain authorization from the insurer for prescribing the minimum length of stay required by this subsection. The policy may provide that an attending provider in consultation with the mother may discharge the mother or the newborn child

1 before the expiration of the minimum length of stay required by this  
2 subsection. The insurer shall not:

3 1. Deny the mother or the newborn child eligibility or continued  
4 eligibility to enroll or to renew coverage under the terms of the policy  
5 solely for the purpose of avoiding the requirements of this subsection.

6 2. Provide monetary payments or rebates to mothers to encourage those  
7 mothers to accept less than the minimum protections available pursuant to  
8 this subsection.

9 3. Penalize or otherwise reduce or limit the reimbursement of an  
10 attending provider because that provider provided care to any insured under  
11 the policy in accordance with this subsection.

12 4. Provide monetary or other incentives to an attending provider to  
13 induce that provider to provide care to an insured under the policy in a  
14 manner that is inconsistent with this subsection.

15 5. Except as described in subsection C of this section, restrict  
16 benefits for any portion of a period within the minimum length of stay in a  
17 manner that is less favorable than the benefits provided for any preceding  
18 portion of that stay.

19 C. Nothing in subsection B of this section:

20 1. Requires a mother to give birth in a hospital or to stay in the  
21 hospital for a fixed period of time following the birth of the child.

22 2. Prevents an insurer from imposing deductibles, coinsurance or other  
23 cost sharing in relation to benefits for hospital lengths of stay in  
24 connection with childbirth for a mother or a newborn child under the policy,  
25 except that any coinsurance or other cost sharing for any portion of a period  
26 within a hospital length of stay required pursuant to subsection B of this  
27 section shall not be greater than the coinsurance or cost sharing for any  
28 preceding portion of that stay.

29 3. Prevents an insurer from negotiating the level and type of  
30 reimbursement with a provider for care provided in accordance with  
31 subsection B of this section.

32 D. Any contract that provides coverage for diabetes shall also provide  
33 coverage for equipment and supplies that are medically necessary and that are  
34 prescribed by a health care provider including:

35 1. Blood glucose monitors.

36 2. Blood glucose monitors for the legally blind.

37 3. Test strips for glucose monitors and visual reading and urine  
38 testing strips.

39 4. Insulin preparations and glucagon.

40 5. Insulin cartridges.

41 6. Drawing up devices and monitors for the visually impaired.

42 7. Injection aids.

43 8. Insulin cartridges for the legally blind.

44 9. Syringes and lancets including automatic lancing devices.

1        10. Prescribed oral agents for controlling blood sugar that are  
2 included on the plan formulary.

3        11. To the extent coverage is required under medicare, podiatric  
4 appliances for prevention of complications associated with diabetes.

5        12. Any other device, medication, equipment or supply for which  
6 coverage is required under medicare from and after January 1, 1999. The  
7 coverage required in this paragraph is effective six months after the  
8 coverage is required under medicare.

9        E. Nothing in subsection D of this section prohibits a group  
10 disability insurer from imposing deductibles, coinsurance or other cost  
11 sharing in relation to benefits for equipment or supplies for the treatment  
12 of diabetes.

13        F. Any contract that provides coverage for prescription drugs shall  
14 not limit or exclude coverage for any prescription drug prescribed for the  
15 treatment of cancer on the basis that the prescription drug has not been  
16 approved by the United States food and drug administration for the treatment  
17 of the specific type of cancer for which the prescription drug has been  
18 prescribed, if the prescription drug has been recognized as safe and  
19 effective for treatment of that specific type of cancer in one or more of the  
20 standard medical reference compendia prescribed in subsection G of this  
21 section or medical literature that meets the criteria prescribed in  
22 subsection G of this section. The coverage required under this subsection  
23 includes covered medically necessary services associated with the  
24 administration of the prescription drug. This subsection does not:

25        1. Require coverage of any prescription drug used in the treatment of  
26 a type of cancer if the United States food and drug administration has  
27 determined that the prescription drug is contraindicated for that type of  
28 cancer.

29        2. Require coverage for any experimental prescription drug that is not  
30 approved for any indication by the United States food and drug  
31 administration.

32        3. Alter any law with regard to provisions that limit the coverage of  
33 prescription drugs that have not been approved by the United States food and  
34 drug administration.

35        4. Require reimbursement or coverage for any prescription drug that is  
36 not included in the drug formulary or list of covered prescription drugs  
37 specified in the contract.

38        5. Prohibit a contract from limiting or excluding coverage of a  
39 prescription drug, if the decision to limit or exclude coverage of the  
40 prescription drug is not based primarily on the coverage of prescription  
41 drugs required by this section.

42        6. Prohibit the use of deductibles, coinsurance, copayments or other  
43 cost sharing in relation to drug benefits and related medical benefits  
44 offered.

45        G. For the purposes of subsection F of this section:

1 1. The acceptable standard medical reference compendia are the  
2 following:

3 ~~(a) The American medical association drug evaluations, a publication~~  
4 ~~of the American medical association.~~

5 ~~(b)~~ (a) The American hospital formulary service drug information, a  
6 publication of the American society of health system pharmacists.

7 ~~(c) Drug information for the health care provider, a publication of~~  
8 ~~the United States pharmacopoeia convention.~~

9 (b) THE NATIONAL COMPREHENSIVE CANCER NETWORK DRUGS AND BIOLOGICS  
10 COMPENDIUM.

11 (c) THOMSON MICROMEDEX COMPENDIUM DRUGDEX.

12 (d) ELSEVIER GOLD STANDARD'S CLINICAL PHARMACOLOGY COMPENDIUM.

13 (e) OTHER AUTHORITATIVE COMPENDIA AS IDENTIFIED BY THE SECRETARY OF  
14 THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

15 2. Medical literature may be accepted if all of the following apply:

16 (a) At least two articles from major peer reviewed professional  
17 medical journals have recognized, based on scientific or medical criteria,  
18 the drug's safety and effectiveness for treatment of the indication for which  
19 the drug has been prescribed.

20 (b) No article from a major peer reviewed professional medical journal  
21 has concluded, based on scientific or medical criteria, that the drug is  
22 unsafe or ineffective or that the drug's safety and effectiveness cannot be  
23 determined for the treatment of the indication for which the drug has been  
24 prescribed.

25 (c) The literature meets the uniform requirements for manuscripts  
26 submitted to biomedical journals established by the international committee  
27 of medical journal editors or is published in a journal specified by the  
28 United States department of health and human services as acceptable peer  
29 reviewed medical literature pursuant to section 186(t)(2)(B) of the social  
30 security act (42 United States Code section 1395x(t)(2)(B)).

31 H. Any contract that is offered by a group disability insurer and that  
32 contains a prescription drug benefit shall provide coverage of medical foods  
33 to treat inherited metabolic disorders as provided by this section.

34 I. The metabolic disorders triggering medical foods coverage under  
35 this section shall:

36 1. Be part of the newborn screening program prescribed in section  
37 36-694.

38 2. Involve amino acid, carbohydrate or fat metabolism.

39 3. Have medically standard methods of diagnosis, treatment and  
40 monitoring including quantification of metabolites in blood, urine or spinal  
41 fluid or enzyme or DNA confirmation in tissues.

42 4. Require specially processed or treated medical foods that are  
43 generally available only under the supervision and direction of a physician  
44 who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse  
45 practitioner who is licensed pursuant to title 32, chapter 15, that must be



1 consumed throughout life and without which the person may suffer serious  
2 mental or physical impairment.

3 J. Medical foods eligible for coverage under this section shall be  
4 prescribed or ordered under the supervision of a physician licensed pursuant  
5 to title 32, chapter 13 or 17 or a registered nurse practitioner who is  
6 licensed pursuant to title 32, chapter 15 as medically necessary for the  
7 therapeutic treatment of an inherited metabolic disease.

8 K. An insurer shall cover at least fifty per cent of the cost of  
9 medical foods prescribed to treat inherited metabolic disorders and covered  
10 pursuant to this section. An insurer may limit the maximum annual benefit  
11 for medical foods under this section to five thousand dollars, which applies  
12 to the cost of all prescribed modified low protein foods and metabolic  
13 formula.

14 L. Any group disability policy that provides coverage for:

15 1. Prescription drugs shall also provide coverage for any prescribed  
16 drug or device that is approved by the United States food and drug  
17 administration for use as a contraceptive. A group disability insurer may  
18 use a drug formulary, multitiered drug formulary or list but that formulary  
19 or list shall include oral, implant and injectable contraceptive drugs,  
20 intrauterine devices and prescription barrier methods if the group disability  
21 insurer does not impose deductibles, coinsurance, copayments or other cost  
22 containment measures for contraceptive drugs that are greater than the  
23 deductibles, coinsurance, copayments or other cost containment measures for  
24 other drugs on the same level of the formulary or list.

25 2. Outpatient health care services shall also provide coverage for  
26 outpatient contraceptive services. For the purposes of this paragraph,  
27 "outpatient contraceptive services" means consultations, examinations,  
28 procedures and medical services provided on an outpatient basis and related  
29 to the use of approved United States food and drug administration  
30 prescription contraceptive methods to prevent unintended pregnancies.

31 M. Notwithstanding subsection L of this section, a religious employer  
32 whose religious tenets prohibit the use of prescribed contraceptive methods  
33 may require that the insurer provide a group disability policy without  
34 coverage for all United States food and drug administration approved  
35 contraceptive methods. A religious employer shall submit a written affidavit  
36 to the insurer stating that it is a religious employer. On receipt of the  
37 affidavit, the insurer shall issue to the religious employer a group  
38 disability policy that excludes coverage of prescription contraceptive  
39 methods. The insurer shall retain the affidavit for the duration of the  
40 group disability policy and any renewals of the policy. Before a policy is  
41 issued, every religious employer that invokes this exemption shall provide  
42 prospective insureds written notice that the religious employer refuses to  
43 cover all United States food and drug administration approved contraceptive  
44 methods for religious reasons. This subsection shall not exclude coverage  
45 for prescription contraceptive methods ordered by a health care provider with

1 prescriptive authority for medical indications other than to prevent an  
2 unintended pregnancy. An insurer may require the insured to first pay for  
3 the prescription and then submit a claim to the insurer along with evidence  
4 that the prescription is for a noncontraceptive purpose. An insurer may  
5 charge an administrative fee for handling these claims. A religious employer  
6 shall not discriminate against an employee who independently chooses to  
7 obtain insurance coverage or prescriptions for contraceptives from another  
8 source.

9 N. For the purposes of:

10 1. This section:

11 (a) "Inherited metabolic disorder" means a disease caused by an  
12 inherited abnormality of body chemistry and includes a disease tested under  
13 the newborn screening program prescribed in section 36-694.

14 (b) "Medical foods" means modified low protein foods and metabolic  
15 formula.

16 (c) "Metabolic formula" means foods that are all of the following:

17 (i) Formulated to be consumed or administered enterally under the  
18 supervision of a physician who is licensed pursuant to title 32, chapter 13  
19 or 17 or a registered nurse practitioner who is licensed pursuant to title  
20 32, chapter 15.

21 (ii) Processed or formulated to be deficient in one or more of the  
22 nutrients present in typical foodstuffs.

23 (iii) Administered for the medical and nutritional management of a  
24 person who has limited capacity to metabolize foodstuffs or certain nutrients  
25 contained in the foodstuffs or who has other specific nutrient requirements  
26 as established by medical evaluation.

27 (iv) Essential to a person's optimal growth, health and metabolic  
28 homeostasis.

29 (d) "Modified low protein foods" means foods that are all of the  
30 following:

31 (i) Formulated to be consumed or administered enterally under the  
32 supervision of a physician who is licensed pursuant to title 32, chapter 13  
33 or 17 or a registered nurse practitioner who is licensed pursuant to title  
34 32, chapter 15.

35 (ii) Processed or formulated to contain less than one gram of protein  
36 per unit of serving, but does not include a natural food that is naturally  
37 low in protein.

38 (iii) Administered for the medical and nutritional management of a  
39 person who has limited capacity to metabolize foodstuffs or certain nutrients  
40 contained in the foodstuffs or who has other specific nutrient requirements  
41 as established by medical evaluation.

42 (iv) Essential to a person's optimal growth, health and metabolic  
43 homeostasis.

44 2. Subsection A of this section, the term "child", for purposes of  
45 initial coverage of an adopted child or a child placed for adoption but not

for purposes of termination of coverage of such child, means a person under the age of eighteen years.

3. Subsection M of this section, "religious employer" means an entity for which all of the following apply:

(a) The entity primarily employs persons who share the religious tenets of the entity.

(b) The entity serves primarily persons who share the religious tenets of the entity.

(c) The entity is a nonprofit organization as described in section 6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.

Sec. 5. Section 20-1404, Arizona Revised Statutes, is amended to read: 20-1404. Blanket disability insurance; definitions

A. Blanket disability insurance is that form of disability insurance covering special groups of persons as enumerated in one of the following paragraphs:

1. Under a policy or contract issued to any common carrier, which shall be deemed the policyholder, covering a group defined as all persons who may become passengers on such common carrier.

2. Under a policy or contract issued to an employer, who shall be deemed the policyholder, covering all employees or any group of employees defined by reference to exceptional hazards incident to such employment. Dependents of the employees and guests of the employer may also be included where exposed to the same hazards.

3. Under a policy or contract issued to a college, school or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or teachers.

4. Under a policy or contract issued in the name of any volunteer fire department or first aid or other such volunteer group, or agency having jurisdiction thereof, which shall be deemed the policyholder, covering all of the members of such fire department or group.

5. Under a policy or contract issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditor.

6. Under a policy or contract issued to a sports team or to a camp or sponsor thereof, which team or camp or sponsor thereof shall be deemed the policyholder, covering members or campers.

7. Under a policy or contract that is issued to any other substantially similar group and that, in the discretion of the director, may be subject to the issuance of a blanket disability policy or contract.

B. An individual application need not be required from a person covered under a blanket disability policy or contract, nor shall it be necessary for the insurer to furnish each person with a certificate.

C. All benefits under any blanket disability policy shall be payable to the person insured, or to the insured's designated beneficiary or beneficiaries, or to the insured's estate, except that if the person insured is a minor, such benefits may be made payable to the insured's parent or

1 guardian or any other person actually supporting the insured, and except that  
2 the policy may provide that all or any portion of any indemnities provided by  
3 any such policy on account of hospital, nursing, medical or surgical services  
4 ~~may~~, at the insurer's option, MAY be paid directly to the hospital or person  
5 rendering such services, but the policy may not require that the service be  
6 rendered by a particular hospital or person. Payment so made shall discharge  
7 the insurer's obligation with respect to the amount of insurance so paid.

8 D. Nothing contained in this section shall be deemed to affect the  
9 legal liability of policyholders for the death of or injury to any member of  
10 the group.

11 E. Any policy or contract, except accidental death and dismemberment,  
12 applied for that provides family coverage ~~shall~~, as to such coverage of  
13 family members, SHALL also provide that the benefits applicable for children  
14 shall be payable with respect to a newly born child of the insured from the  
15 instant of such child's birth, to a child adopted by the insured, regardless  
16 of the age at which the child was adopted, and to a child who has been placed  
17 for adoption with the insured and for whom the application and approval  
18 procedures for adoption pursuant to section 8-105 or 8-108 have been  
19 completed to the same extent that such coverage applies to other members of  
20 the family. The coverage for newly born or adopted children or children  
21 placed for adoption shall include coverage of injury or sickness including  
22 necessary care and treatment of medically diagnosed congenital defects and  
23 birth abnormalities. If payment of a specific premium is required to provide  
24 coverage for a child, the policy or contract may require that notification of  
25 birth, adoption or adoption placement of the child and payment of the  
26 required premium must be furnished to the insurer within thirty-one days  
27 after the date of birth, adoption or adoption placement in order to have the  
28 coverage continue beyond the thirty-one day period.

29 F. Each policy or contract shall be so written that the insurer shall  
30 pay benefits:

31 1. For performance of any surgical service that is covered by the  
32 terms of such contract, regardless of the place of service.

33 2. For any home health services that are performed by a licensed home  
34 health agency and that a physician has prescribed in lieu of hospital  
35 services, as defined by the director, providing the hospital services would  
36 have been covered.

37 3. For any diagnostic service that a physician has performed outside a  
38 hospital in lieu of inpatient service, providing the inpatient service would  
39 have been covered.

40 4. For any service performed in a hospital's outpatient department or  
41 in a freestanding surgical facility, providing such service would have been  
42 covered if performed as an inpatient service.

43 G. A blanket disability insurance policy that provides coverage for  
44 the surgical expense of a mastectomy shall also provide coverage incidental  
45 to the patient's covered mastectomy for the expense of reconstructive surgery

1 of the breast on which the mastectomy was performed, surgery and  
2 reconstruction of the other breast to produce a symmetrical appearance,  
3 prostheses, treatment of physical complications for all stages of the  
4 mastectomy, including lymphedemas, and at least two external postoperative  
5 prostheses subject to all of the terms and conditions of the policy.

6 H. A contract that provides coverage for surgical services for a  
7 mastectomy shall also provide coverage for mammography screening performed on  
8 dedicated equipment for diagnostic purposes on referral by a patient's  
9 physician, subject to all of the terms and conditions of the policy and  
10 according to the following guidelines:

11 1. A baseline mammogram for a woman from age thirty-five to  
12 thirty-nine.

13 2. A mammogram for a woman from age forty to forty-nine every two  
14 years or more frequently based on the recommendation of the woman's  
15 physician.

16 3. A mammogram every year for a woman fifty years of age and over.

17 I. Any contract that is issued to the insured and that provides  
18 coverage for maternity benefits shall also provide that the maternity  
19 benefits apply to the costs of the birth of any child legally adopted by the  
20 insured if all the following are true:

21 1. The child is adopted within one year of birth.

22 2. The insured is legally obligated to pay the costs of birth.

23 3. All preexisting conditions and other limitations have been met by  
24 the insured.

25 4. The insured has notified the insurer of his acceptability to adopt  
26 children pursuant to section 8-105, within sixty days after such approval or  
27 within sixty days after a change in insurance policies, plans or companies.

28 J. The coverage prescribed by subsection I of this section is excess  
29 to any other coverage the natural mother may have for maternity benefits  
30 except coverage made available to persons pursuant to title 36, chapter 29,  
31 but not including coverage made available to persons defined as eligible  
32 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If  
33 such other coverage exists the agency, attorney or individual arranging the  
34 adoption shall make arrangements for the insurance to pay those costs that  
35 may be covered under that policy and shall advise the adopting parent in  
36 writing of the existence and extent of the coverage without disclosing any  
37 confidential information such as the identity of the natural parent. The  
38 insured adopting parents shall notify their insurer of the existence and  
39 extent of the other coverage.

40 K. Any contract that provides maternity benefits shall not restrict  
41 benefits for any hospital length of stay in connection with childbirth for  
42 the mother or the newborn child to less than forty-eight hours following a  
43 normal vaginal delivery or ninety-six hours following a cesarean section.  
44 The contract shall not require the provider to obtain authorization from the  
45 insurer for prescribing the minimum length of stay required by this

subsection. The contract may provide that an attending provider in consultation with the mother may discharge the mother or the newborn child before the expiration of the minimum length of stay required by this subsection. The insurer shall not:

1. Deny the mother or the newborn child eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract solely for the purpose of avoiding the requirements of this subsection.

2. Provide monetary payments or rebates to mothers to encourage those mothers to accept less than the minimum protections available pursuant to this subsection.

3. Penalize or otherwise reduce or limit the reimbursement of an attending provider because that provider provided care to any insured under the contract in accordance with this subsection.

4. Provide monetary or other incentives to an attending provider to induce that provider to provide care to an insured under the contract in a manner that is inconsistent with this subsection.

5. Except as described in subsection L of this section, restrict benefits for any portion of a period within the minimum length of stay in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

L. Nothing in subsection K of this section:

1. Requires a mother to give birth in a hospital or to stay in the hospital for a fixed period of time following the birth of the child.

2. Prevents an insurer from imposing deductibles, coinsurance or other cost sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn child under the contract, except that any coinsurance or other cost sharing for any portion of a period within a hospital length of stay required pursuant to subsection K of this section shall not be greater than the coinsurance or cost sharing for any preceding portion of that stay.

3. Prevents an insurer from negotiating the level and type of reimbursement with a provider for care provided in accordance with subsection K of this section.

M. Any contract that provides coverage for diabetes shall also provide coverage for equipment and supplies that are medically necessary and that are prescribed by a health care provider including:

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

3. Test strips for glucose monitors and visual reading and urine testing strips.

4. Insulin preparations and glucagon.

5. Insulin cartridges.

6. Drawing up devices and monitors for the visually impaired.

7. Injection aids.

8. Insulin cartridges for the legally blind.

1           9. Syringes and lancets including automatic lancing devices.

2           10. Prescribed oral agents for controlling blood sugar that are  
3 included on the plan formulary.

4           11. To the extent coverage is required under medicare, podiatric  
5 appliances for prevention of complications associated with diabetes.

6           12. Any other device, medication, equipment or supply for which  
7 coverage is required under medicare from and after January 1, 1999. The  
8 coverage required in this paragraph is effective six months after the  
9 coverage is required under medicare.

10          N. Nothing in subsection M of this section prohibits a blanket  
11 disability insurer from imposing deductibles, coinsurance or other cost  
12 sharing in relation to benefits for equipment or supplies for the treatment  
13 of diabetes.

14          O. Any contract that provides coverage for prescription drugs shall  
15 not limit or exclude coverage for any prescription drug prescribed for the  
16 treatment of cancer on the basis that the prescription drug has not been  
17 approved by the United States food and drug administration for the treatment  
18 of the specific type of cancer for which the prescription drug has been  
19 prescribed, if the prescription drug has been recognized as safe and  
20 effective for treatment of that specific type of cancer in one or more of the  
21 standard medical reference compendia prescribed in subsection P of this  
22 section or medical literature that meets the criteria prescribed in  
23 subsection P of this section. The coverage required under this subsection  
24 includes covered medically necessary services associated with the  
25 administration of the prescription drug. This subsection does not:

26           1. Require coverage of any prescription drug used in the treatment of  
27 a type of cancer if the United States food and drug administration has  
28 determined that the prescription drug is contraindicated for that type of  
29 cancer.

30           2. Require coverage for any experimental prescription drug that is not  
31 approved for any indication by the United States food and drug  
32 administration.

33           3. Alter any law with regard to provisions that limit the coverage of  
34 prescription drugs that have not been approved by the United States food and  
35 drug administration.

36           4. Require reimbursement or coverage for any prescription drug that is  
37 not included in the drug formulary or list of covered prescription drugs  
38 specified in the contract.

39           5. Prohibit a contract from limiting or excluding coverage of a  
40 prescription drug, if the decision to limit or exclude coverage of the  
41 prescription drug is not based primarily on the coverage of prescription  
42 drugs required by this section.

43           6. Prohibit the use of deductibles, coinsurance, copayments or other  
44 cost sharing in relation to drug benefits and related medical benefits  
45 offered.

1 P. For the purposes of subsection O of this section:

2 1. The acceptable standard medical reference compendia are the  
3 following:

4 ~~(a) The American medical association drug evaluations, a publication~~  
5 ~~of the American medical association.~~

6 ~~(b)~~ (a) The American hospital formulary service drug information, a  
7 publication of the American society of health system pharmacists.

8 ~~(c) Drug information for the health care provider, a publication of~~  
9 ~~the United States pharmacopoeia convention.~~

10 (b) THE NATIONAL COMPREHENSIVE CANCER NETWORK DRUGS AND BIOLOGICS  
11 COMPENDIUM.

12 (c) THOMSON MICROMEDEX COMPENDIUM DRUGDEX.

13 (d) ELSEVIER GOLD STANDARD'S CLINICAL PHARMACOLOGY COMPENDIUM.

14 (e) OTHER AUTHORITATIVE COMPENDIA AS IDENTIFIED BY THE SECRETARY OF  
15 THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

16 2. Medical literature may be accepted if all of the following apply:

17 (a) At least two articles from major peer reviewed professional  
18 medical journals have recognized, based on scientific or medical criteria,  
19 the drug's safety and effectiveness for treatment of the indication for which  
20 the drug has been prescribed.

21 (b) No article from a major peer reviewed professional medical journal  
22 has concluded, based on scientific or medical criteria, that the drug is  
23 unsafe or ineffective or that the drug's safety and effectiveness cannot be  
24 determined for the treatment of the indication for which the drug has been  
25 prescribed.

26 (c) The literature meets the uniform requirements for manuscripts  
27 submitted to biomedical journals established by the international committee  
28 of medical journal editors or is published in a journal specified by the  
29 United States department of health and human services as acceptable peer  
30 reviewed medical literature pursuant to section 186(t)(2)(B) of the social  
31 security act (42 United States Code section 1395x(t)(2)(B)).

32 Q. Any contract that is offered by a blanket disability insurer and  
33 that contains a prescription drug benefit shall provide coverage of medical  
34 foods to treat inherited metabolic disorders as provided by this section.

35 R. The metabolic disorders triggering medical foods coverage under  
36 this section shall:

37 1. Be part of the newborn screening program prescribed in section  
38 36-694.

39 2. Involve amino acid, carbohydrate or fat metabolism.

40 3. Have medically standard methods of diagnosis, treatment and  
41 monitoring including quantification of metabolites in blood, urine or spinal  
42 fluid or enzyme or DNA confirmation in tissues.

43 4. Require specially processed or treated medical foods that are  
44 generally available only under the supervision and direction of a physician  
45 who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse



1 practitioner who is licensed pursuant to title 32, chapter 15, that must be  
2 consumed throughout life and without which the person may suffer serious  
3 mental or physical impairment.

4 S. Medical foods eligible for coverage under this section shall be  
5 prescribed or ordered under the supervision of a physician licensed pursuant  
6 to title 32, chapter 13 or 17 or a registered nurse practitioner who is  
7 licensed pursuant to title 32, chapter 15 as medically necessary for the  
8 therapeutic treatment of an inherited metabolic disease.

9 T. An insurer shall cover at least fifty per cent of the cost of  
10 medical foods prescribed to treat inherited metabolic disorders and covered  
11 pursuant to this section. An insurer may limit the maximum annual benefit  
12 for medical foods under this section to five thousand dollars which applies  
13 to the cost of all prescribed modified low protein foods and metabolic  
14 formula.

15 U. Any blanket disability policy that provides coverage for:

16 1. Prescription drugs shall also provide coverage for any prescribed  
17 drug or device that is approved by the United States food and drug  
18 administration for use as a contraceptive. A blanket disability insurer may  
19 use a drug formulary, multitiered drug formulary or list but that formulary  
20 or list shall include oral, implant and injectable contraceptive drugs,  
21 intrauterine devices and prescription barrier methods if the blanket  
22 disability insurer does not impose deductibles, coinsurance, copayments or  
23 other cost containment measures for contraceptive drugs that are greater than  
24 the deductibles, coinsurance, copayments or other cost containment measures  
25 for other drugs on the same level of the formulary or list.

26 2. Outpatient health care services shall also provide coverage for  
27 outpatient contraceptive services. For the purposes of this paragraph,  
28 "outpatient contraceptive services" means consultations, examinations,  
29 procedures and medical services provided on an outpatient basis and related  
30 to the use of approved United States food and drug administration  
31 prescription contraceptive methods to prevent unintended pregnancies.

32 V. Notwithstanding subsection U of this section, a religious employer  
33 whose religious tenets prohibit the use of prescribed contraceptive methods  
34 may require that the insurer provide a blanket disability policy without  
35 coverage for all United States food and drug administration approved  
36 contraceptive methods. A religious employer shall submit a written affidavit  
37 to the insurer stating that it is a religious employer. On receipt of the  
38 affidavit, the insurer shall issue to the religious employer a blanket  
39 disability policy that excludes coverage of prescription contraceptive  
40 methods. The insurer shall retain the affidavit for the duration of the  
41 blanket disability policy and any renewals of the policy. Before a policy is  
42 issued, every religious employer that invokes this exemption shall provide  
43 prospective insureds written notice that the religious employer refuses to  
44 cover all United States food and drug administration approved contraceptive  
45 methods for religious reasons. This subsection shall not exclude coverage

1 for prescription contraceptive methods ordered by a health care provider with  
2 prescriptive authority for medical indications other than to prevent an  
3 unintended pregnancy. An insurer may require the insured to first pay for  
4 the prescription and then submit a claim to the insurer along with evidence  
5 that the prescription is for a noncontraceptive purpose. An insurer may  
6 charge an administrative fee for handling these claims under this subsection.  
7 A religious employer shall not discriminate against an employee who  
8 independently chooses to obtain insurance coverage or prescriptions for  
9 contraceptives from another source.

10 W. For the purposes of:

11 1. This section:

12 (a) "Inherited metabolic disorder" means a disease caused by an  
13 inherited abnormality of body chemistry and includes a disease tested under  
14 the newborn screening program prescribed in section 36-694.

15 (b) "Medical foods" means modified low protein foods and metabolic  
16 formula.

17 (c) "Metabolic formula" means foods that are all of the following:

18 (i) Formulated to be consumed or administered enterally under the  
19 supervision of a physician who is licensed pursuant to title 32, chapter 13  
20 or 17 or a registered nurse practitioner who is licensed pursuant to title  
21 32, chapter 15.

22 (ii) Processed or formulated to be deficient in one or more of the  
23 nutrients present in typical foodstuffs.

24 (iii) Administered for the medical and nutritional management of a  
25 person who has limited capacity to metabolize foodstuffs or certain nutrients  
26 contained in the foodstuffs or who has other specific nutrient requirements  
27 as established by medical evaluation.

28 (iv) Essential to a person's optimal growth, health and metabolic  
29 homeostasis.

30 (d) "Modified low protein foods" means foods that are all of the  
31 following:

32 (i) Formulated to be consumed or administered enterally under the  
33 supervision of a physician who is licensed pursuant to title 32, chapter 13  
34 or 17 or a registered nurse practitioner who is licensed pursuant to title  
35 32, chapter 15.

36 (ii) Processed or formulated to contain less than one gram of protein  
37 per unit of serving, but does not include a natural food that is naturally  
38 low in protein.

39 (iii) Administered for the medical and nutritional management of a  
40 person who has limited capacity to metabolize foodstuffs or certain nutrients  
41 contained in the foodstuffs or who has other specific nutrient requirements  
42 as established by medical evaluation.

43 (iv) Essential to a person's optimal growth, health and metabolic  
44 homeostasis.

2. Subsection E of this section, the term "child", for purposes of initial coverage of an adopted child or a child placed for adoption but not for purposes of termination of coverage of such child, means a person under the age of eighteen years.

3. Subsection V of this section, "religious employer" means an entity for which all of the following apply:

(a) The entity primarily employs persons who share the religious tenets of the entity.

(b) The entity serves primarily persons who share the religious tenets of the entity.

(c) The entity is a nonprofit organization as described in section 6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.

Sec. 6. Section 20-2326, Arizona Revised Statutes, is amended to read:

20-2326. Drugs; cancer treatment; definitions

A. Any health benefits plan that is offered by an accountable health plan and that provides coverage for prescription drugs shall not limit or exclude coverage for any prescription drug prescribed for the treatment of cancer on the basis that the prescription drug has not been approved by the United States food and drug administration for the treatment of the specific type of cancer for which the prescription drug has been prescribed, if the prescription drug has been recognized as safe and effective for treatment of that specific type of cancer in one or more of the standard medical reference compendia prescribed in subsection B or medical literature that meets the criteria prescribed in subsection B. The coverage required under this subsection includes covered medically necessary services associated with the administration of the prescription drug. This subsection does not:

1. Require coverage of any prescription drug used in the treatment of a type of cancer if the United States food and drug administration has determined that the prescription drug is contraindicated for that type of cancer.

2. Require coverage for any experimental prescription drug that is not approved for any indication by the United States food and drug administration.

3. Alter any law with regard to provisions that limit the coverage of prescription drugs that have not been approved by the United States food and drug administration.

4. Require reimbursement or coverage for any prescription drug that is not included in the drug formulary or list of covered prescription drugs specified in the health benefits plan.

5. Prohibit a health benefits plan from limiting or excluding coverage of a prescription drug, if the decision to limit or exclude coverage of the prescription drug is not based primarily on the coverage of prescription drugs required by this section.

1           6. Prohibit the use of deductibles, coinsurance, copayments or other  
2 cost sharing in relation to drug benefits and related medical benefits  
3 offered.

4           B. For the purposes of subsection A:

5           1. The acceptable standard medical reference compendia are the  
6 following:

7           ~~(a) The American medical association drug evaluations, a publication~~  
8 ~~of the American medical association.~~

9           ~~(b)~~ (a) The American hospital formulary service drug information, a  
10 publication of the American society of health system pharmacists.

11           ~~(c) Drug information for the health care provider, a publication of~~  
12 ~~the United States pharmacopoeia convention.~~

13           (b) THE NATIONAL COMPREHENSIVE CANCER NETWORK DRUGS AND BIOLOGICS  
14 COMPENDIUM.

15           (c) THOMSON MICROMEDEX COMPENDIUM DRUGDEX.

16           (d) ELSEVIER GOLD STANDARD'S CLINICAL PHARMACOLOGY COMPENDIUM.

17           (e) OTHER AUTHORITATIVE COMPENDIA AS IDENTIFIED BY THE SECRETARY OF  
18 THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

19           2. Medical literature may be accepted if all of the following apply:

20           (a) At least two articles from major peer reviewed professional  
21 medical journals have recognized, based on scientific or medical criteria,  
22 the drug's safety and effectiveness for treatment of the indication for which  
23 the drug has been prescribed.

24           (b) No article from a major peer reviewed professional medical journal  
25 has concluded, based on scientific or medical criteria, that the drug is  
26 unsafe or ineffective or that the drug's safety and effectiveness cannot be  
27 determined for the treatment of the indication for which the drug has been  
28 prescribed.

29           (c) The literature meets the uniform requirements for manuscripts  
30 submitted to biomedical journals established by the international committee  
31 of medical journal editors or is published in a journal specified by the  
32 United States department of health and human services as acceptable peer  
33 reviewed medical literature pursuant to section 186(t)(2)(B) of the social  
34 security act (42 United States Code section 1395x(t)(2)(B)).